Invited Commentary

Improving Health Care Accessibility for People With Vision Impairment—A Call to Account

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Related article

In this issue of *JAMA Ophthalmology*, an article by Iezzoni et al[1] reports on the extent to which US physicians provide 2 basic accommodations—describing the clinic space and providing materials in large font—when caring for people with severe visual limitations. The nationwide survey of physicians across 7 specialties found less than 10% provided both accommodations while 60% provided neither; ophthalmologists (24%) fared only slightly better than other physicians (less than 8.5%) at providing both accommodations.

We commend the authors for highlighting an extremely neglected topic and share their concern with the findings. As Iezzoni and colleagues[1] point out in their article, this lack of accommodation occurred despite the Americans with Disabilities Act being in place for more than 3 decades. Furthermore, the need to uphold standards of dignity and rights for people with disability has pervaded public discourse worldwide since the adoption of the United Nations Convention on the Rights of Persons with Disabilities in 2007,[2] although the US is notable in its absence among ratifying countries. The findings reported by Iezzoni and colleagues[1] highlight neglect of 2 key articles of the convention. Article 9 ensures accessibility for persons with disability to participate fully in all aspects of life and article 25 ensures the specific right to health, which requires health care professionals to provide the same quality of care to persons with disability as to others, including based on free and informed consent.[2]

While the reported results are alarming, there are several reasons why the reality for many patients with vision-related disability may be worse. First, the very low rate of accommodations identified in the article by Iezzoni et al[1] may be overestimates. There is potential for self-selection bias, with physicians more actively providing services for people with disability to be more likely to participate in the study. Positive-response bias is also likely, with participants overestimating the number and frequency of accommodations they provide. Further, these 2 basic accommodations represent an extremely low bar, and their provision does not necessarily reflect the provision of high-quality, person-centered care. Additionally, we acknowledge that many people with vision impairment live in countries without policies and regulations focused on achieving equity for people with disability.

The recent *Lancet Global Health* Commission on Global Eye Health[3] took steps to redress the historic undervaluing of interventions other than those related to sight in global eye health. One such step—to which we contributed—was to explicitly define eye health as "the state in which vision, ocular health, and functional ability are maximised, thereby contributing to overall health and wellbeing, social inclusion, and quality of life."[3] By including functional ability alongside vision and ocular health, this definition elevates vision rehabilitation and the rights of people with vision impairment. The commission called for 2 actions to reduce barriers to daily functioning. The first was for vision rehabilitation services to be more accessible to people with vision impairment. The second was to create more inclusive environments through policies and laws, assistive technology, inclusive education, vocational training, advocacy, and accessible spaces. Further, the commission highlighted the opportunity provided by integrated people-centered eye care[4] to reorient services that promote the rights of people with vision loss to access the health care services and eye health services they require across the life course, which is not limited to the condition causing their vision impairment. The article by Iezzoni and colleagues[1] highlights the urgent need for these recommendations to translate to real action.

We believe ophthalmologists have unique responsibilities and obligations to people with vision-related disability beyond those of other physicians. Applying a concept of social justice put forward by political theorist David Miller, PhD, such obligations can be defined as "special duties" when the relationship between individuals or groups is intrinsically valuable, the duties are integral to the relationship, and where the attachments that underpin the relationship are not inherently unjust.[5]

These conditions are evident in the primary relationship between ophthalmologists and patients with vision impairment. Ophthalmology is directly concerned with vision and ocular health, and the nature of vision-related disability is that which is caused by the interaction between vision impairment and attitudinal and environmental barriers. Therefore, the duty to maximize positive outcomes and minimize harm related to vision-related disability, whether that be in improving sight or in removing barriers arising from a vision-centric environment, ought to be equally integral to the relationship between physician and patient.

For too long, and as Iezzoni et al[1] demonstrate, the unique barriers that people with vision impairment face have been ignored in health care settings, which translate to broader health inequities. Removing these barriers within health care settings should be equally integral to patient care as are efforts to improve sight. The findings pertaining to ophthalmologists are unacceptably low and suggest that further training is needed in the principles of accessibility and disability inclusion to ensure patients with vision impairment have equitable opportunities for person-centered health care.

However, equitable access to health care for people with vision-related disability should not be the sole duty of ophthalmologists. We posit that all physicians have obligations to maximize the health of people with vision impairment, owing to the nature of medicine and its unique Hippocratic oath. These obligations were reinforced by the revised Declaration of Geneva[6] adopted by the World Medical Association in 2017. Physicians pledge to hold the health and well-being of patients as the first consideration, followed by a commitment to respect the autonomy and dignity of patients.[6] This commitment should compel all physicians to reflect on the accommodations they provide to their patients with vision impairment, and undertake positive actions to ensure these patients fully enjoy their rights. As highlighted by Iezzoni and colleagues,[1] these actions should include ensuring equitable access to physical and virtual environments, accessible information, and informed consent.

Further, patients with vision impairment must be partners in the process to create more inclusive environments. Efforts to make health care more accessible must stem from the patients experiencing these barriers. Ophthalmologists and other health care practitioners must look to patients to understand their unique health care challenges and identify pragmatic solutions.

We hope the results from Iezzoni et al[1] compel ophthalmologists and other eye health practitioners to hold themselves accountable to look beyond disease and impairing conditions and to see the whole patient. Our field has a unique responsibility to maximize the health, well-being, and social inclusion of people with vision-related disability. Creating accessible health care environments is necessary for equity, autonomy, and the rights of people with vision impairment.

ARTICLE INFORMATION

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